COMMONWEALTH OF VIRGINIA

Department of Health Professions Board of Counseling

Perimeter Center 9960 Mayland Drive, Suite 300 Henrico, VA 23233-1463 Email: coun@dhp.virginia.gov

Phone: (804) 367-4610 Fax: (804) 527-4435 Website: www.dhp.virginia.gov/counseling

CSAC VERIFICATION OF CLINICAL SUPERVISION

GENERAL INFORMATION PLEASE TYPE OR PRINT CLEARLY		USE BLUE OR BLACK INK		
Name o	f Applicant (Last, First, Middle)	Applicants Email Address		
SUPER	VISOR'S EVALUATION:			
Supervi	sor's Name (Last, First)		Supervisor's Telepl Number	none
Supervi	sor's License/Certification Type:	Supervisor's License/Certificati	on Number:	
Busines	s Name and Address of Work Site Where Clinical Hours W	ere Obtained (ONE LOCATION	N ONLY)	
Dates of	f supervision: From:toto	(Circle Yes or No)		
Dild		Yes	No	
	applicant receive a minimum of one (1) hour and a maximu pervision per week while under your direct supervision?	If not, explain on separate page		
			Yes	No
	applicant receive a minimum of 100 total hours of supervis hours obtained in group supervision while under your direc		If not, how r	nany?
			Yes	No
Did applicant complete a minimum of 2,000 hours of supervised experience in the delivery of clinical substance abuse counseling services?			If not, how many?	
Did the applicant demonstrate minimum competencies of applying a counseling process, treatment strategies and rehabilitative services to help an individual to:				
a.	Understand his substance abuse use, abuse or dependency?		Yes	No
b.	Change his drug-taking behaviors so that it does not interfer psychological, social or vocational functioning?	e with effective physical,	Yes	No
Did the applicant complete a minimum of 180 hours of experience performing the following tasks with substance abuse clients with <u>at least eight hours</u> for each task?				
a.	Screening clients to determine eligibility and appropriaten program	ess for admission to a particular	Yes	No
b.	Intake of clients by performing the administrative and initi for admission to a program;	al assessment tasks necessary	Yes	No
c.	Orientation of new clients to program's rules, goals, proceeding the client;	dures, services, costs and the	Yes	No
d.	Assessment of client's strengths, weaknesses, problems, are a treatment plan;	nd needs for the development of	Yes	No
e.	Treatment planning with the client to identify and rank pro- establish goals, and agree on treatment processes;	oblems to be addressed,	Yes	No

Revised 02/2017 4

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<u>CS</u>	AC VERIFICATION OF CLINICAL SUPERVISION – Page 2	(Circle Y	es or No)
f.	Counseling the client utilizing specialized skills in both individual and group approaches to achieve treatment goals and objectives;	Yes	No
g.	Case management activities which bring services, agencies, people and resources together in a planned framework of action to achieve established goals;	Yes	No
h.	Crisis intervention responses to clients' needs during acute mental, emotional or physical distress;	Yes	No
i.	Education of clients by providing information about drug abuse and available services and resources;	Yes	No
j.	Referral of clients in order to meet identified needs unable to be met by the counselor and assisting the client in effectively utilizing those resources;	Yes	No
k.	Reporting and charting information about client's assessment, treatment plan, progress, discharge summaries and other client-related data; and	Yes	No
1.	Consultation with other professionals to assure comprehensive quality care for the client	Yes	No
	opinion has the applicant demonstrated competency sufficient for certification of substance ounseling?	Yes	No
declar	e that, to the best of my knowledge, the foregoing is true and correct.		
	Supervisor's Signature Date		

Revised 02/2017 5